FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044362

Facility Name: RESURRECTION NURSING & REHABILITATION CENTER

Address: 1001 NORTH GREENWOOD (Number) PARK RIDGE (City) 60068 (Zip Code)

County: COOK

Telephone Number: 847-692-5600 **Fax #** 847-692-2305

IDPA ID Number: 23-7061646-004

Date of Initial License for Current Owners: 05-01-80

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501-C-3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: STEVEN LAVENDA, CPA **Telephone Number:** 847-236-1111 ext. 330

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/99 to 06/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed) SEE ACCOUNTANT'S REPORT ATTACHED	(Date)
	(Print Name and Title) Richard Sgarlata, C.P.A.	
	(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015	
	(Telephone) (847) 236-1111	Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CENTER # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	298	Skilled (SNF)	298	109,068	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	298	TOTALS	298	109,068	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	26,028	51,345	19,753	97,126	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,028	51,345	19,753	97,126	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.05%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/80

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/80 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 78 and days of care provided 19,753

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/00 Fiscal Year: 06/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number RESURRECTION NURSING & REHABILI # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	575,385	5,280		580,665		580,665	90,320	670,985			1
2	Food Purchase		588,932		588,932		588,932	73,720	662,652			2
3	Housekeeping	318,851	139,534		458,385		458,385	78,506	536,891			3
4	Laundry	153,097	77,496		230,593		230,593	38,961	269,554			4
5	Heat and Other Utilities			266,938	266,938		266,938	41,459	308,397			5
6	Maintenance	134,412	18,542	115,938	268,892		268,892	43,243	312,135			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,181,745	829,784	382,876	2,394,405		2,394,405	366,209	2,760,614			8
	B. Health Care and Programs											
9	Medical Director			18,876	18,876		18,876	2,929	21,805			9
10	Nursing and Medical Records	4,429,013	154,509	278,895	4,862,417		4,862,417	760,699	5,623,116			10
10a	Therapy	373,129			373,129		373,129	57,931	431,060			10a
11	Activities	141,318			141,318		141,318	22,109	163,427			11
12	Social Services	227,990			227,990		227,990	35,380	263,370			12
13	Nurse Aide Training											13
14	Program Transportation			2,552	2,552		2,552	91	2,643			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	5,171,450	154,509	300,323	5,626,282		5,626,282	879,139	6,505,421			16
	C. General Administration											
17	Administrative	212,421		949,785	1,162,206		1,162,206	(769,431)	392,775			17
18	Directors Fees											18
19	Professional Services			18,131	18,131		18,131	191,132	209,263			19
20	Dues, Fees, Subscriptions & Promotions			25,038	25,038		25,038	(9,535)	15,503			20
21	Clerical & General Office Expenses	309,074	62,114	55,707	426,895		426,895	225,527	652,422			21
22	Employee Benefits & Payroll Taxes			1,657,638	1,657,638		1,657,638	257,236	1,914,874			22
23	Inservice Training & Education			3,474	3,474		3,474	539	4,013			23
24	Travel and Seminar			14,805	14,805		14,805	568	15,373			24
25	Other Admin. Staff Transportation			542	542		542	497	1,039			25
26	Insurance-Prop.Liab.Malpractice			251,483	251,483		251,483	39,026	290,509			26
27	Other (specify):*											27
28	**TOTAL General Administration**	521,495	62,114	2,976,603	3,560,212		3,560,212	(64,441)	3,495,771			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,874,690	1,046,407	3,659,802	11,580,899		11,580,899	1,180,907	12,761,806			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

RESURRECTION NURSING & REHABILITATION CENTER **0044362**

COST REPORT RECLASSIFICATIONS

07/01/99

06/30/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS		
2	FOOD		

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CENT #0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			633,888	633,888		633,888	97,889	731,777			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			63,439	63,439		63,439	12,644	76,083			35
36	Other (specify):*											36
37	**TOTAL Ownership**			697,327	697,327		697,327	110,533	807,860			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	541,860	1,013,491	142,588	1,697,939		1,697,939	204,619	1,902,558			39
40	Barber and Beauty Shops			28,800	28,800		28,800	4,469	33,269			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			163,602	163,602		163,602		163,602			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	541,860	1,013,491	334,990	1,890,341		1,890,341	209,088	2,099,429			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,416,550	2,059,898	4,692,119	14,168,567		14,168,567	1,500,528	15,669,095			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CE # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(17,727)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	448	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(13,580)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(20,795)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (51,654)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,552,182		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,552,182		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,500,528		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

RESURRECTION NURSING & REHABILITATION CENTER

ID# 0044362

Report Period Beginning: 07/01/99

Ending: 06/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Out of State Travel	(1,951)	24	2
3	Misc. Income	(469)	21	3
4	Collection Agency Fees	(643)	19	4
5	Bank Charges	(12,323)	21	5
6	Non-Care Related Depreciation	(927)	30	6
7	Capitalized Repairs	(4,482)	6	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(20,795)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CEN # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	183	90,137	0	0	0	0	0	0	0	0	90,320	1
2	Food Purchase	(17,727)	48	91,399	0	0	0	0	0	0	0	0	73,720	2
3	Housekeeping	0	6,382	72,124	0	0	0	0	0	0	0	0	78,506	3
4	Laundry	0	2,750	36,211	0	0	0	0	0	0	0	0	38,961	4
5	Heat and Other Utilities	0	30	41,429	0	0	0	0	0	0	0	0	41,459	5
6	Maintenance	(4,482)	5,192	42,533	0	0	0	0	0	0	0	0	43,243	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(22,209)	14,585	373,833	0	0	0	0	0	0	0	0	366,209	8
	B. Health Care and Programs													
9	Medical Director	0	0	2,929	0	0	0	0	0	0	0	0	2,929	9
10	Nursing and Medical Records	0	5,314	755,385	0	0	0	0	0	0	0	0	760,699	10
10a	Therapy	0	0	57,931	0	0	0	0	0	0	0	0	57,931	10a
11	Activities	0	179	21,930	0	0	0	0	0	0	0	0	22,109	11
12	Social Services	0	0	35,380	0	0	0	0	0	0	0	0	35,380	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	91	0	0	0	0	0	0	0	0	91	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	5,493	873,646	0	0	0	0	0	0	0	0	879,139	16
	C. General Administration													
17	Administrative	0	0	180,354	(949,785)	0	0	0	0	0	0	0	(769,431)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(643)	163,577	28,198	0	0	0	0	0	0	0	0	191,132	19
20	Fees, Subscriptions & Promotions	(13,580)	138	3,907	0	0	0	0	0	0	0	0	(9,535)	20
21	Clerical & General Office Expenses	(12,792)	146,739	91,580	0	0	0	0	0	0	0	0	225,527	21
22	Employee Benefits & Payroll Taxes	0	0	257,236	0	0	0	0	0	0	0	0	257,236	22
23	Inservice Training & Education	0	0	539	0	0	0	0	0	0	0	0	539	23
24	Travel and Seminar	(1,951)	0	2,519	0	0	0	0	0	0	0	0	568	24
25	Other Admin. Staff Transportation	0	0	94	403	0	0	0	0	0	0	0	497	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	39,026	0	0	0	0	0	0	0	39,026	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(28,966)	310,454	564,427	(910,356)	0	0	0	0	0	0	0	(64,441)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(51,175)	330,532	1,811,906	(910,356)	0	0	0	0	0	0	0	1,180,907	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CEN # 0044362 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(479)	0	0	98,368	0	0	0	0	0	0	0	97,889	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	2,423	10,221	0	0	0	0	0	0	0	12,644	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(479)	0	2,423	108,589	0	0	0	0	0	0	0	110,533	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	7,972	196,647	0	0	0	0	0	0	0	204,619	39
40	Barber and Beauty Shops	0	0	0	4,469	0	0	0	0	0	0	0	4,469	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	7,972	201,116	0	0	0	0	0	0	0	209,088	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(51,654)	330,532	1,822,301	(600,651)	0	0	0	0	0	0	0	1,500,528	45

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CENTER # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Resurrection Health Care	100	See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		21		$	Resurrection Health Care/Resurrection Medical Center		$ 3,009	$ 3,009	1
2	V		19					163,384	163,384	2
3	V		21					143,730	143,730	3
4	V		1					183	183	4
5	V		2					48	48	5
6	V		3					6,382	6,382	6
7	V		4					2,750	2,750	7
8	V		5					30	30	8
9	V		6					5,192	5,192	9
10	V		10					5,314	5,314	10
11	V		11					179	179	11
12	V		19					193	193	12
13	V		20					138	138	13
14	Total				$			$ 330,532	$ * 330,532	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CENTER # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21		$	Resurrection Health Care/Resurrection Medical Center		$ 2,218	$ 2,218	15
16	V	24					192	192	16
17	V	25					94	94	17
18	V	35					2,423	2,423	18
19	V	39					7,972	7,972	19
20	V	1					90,137	90,137	20
21	V	2					91,399	91,399	21
22	V	3					72,124	72,124	22
23	V	4					36,211	36,211	23
24	V	5					41,429	41,429	24
25	V	6					42,533	42,533	25
26	V	9					2,929	2,929	26
27	V	10					755,385	755,385	27
28	V	10a					57,931	57,931	28
29	V	11					21,930	21,930	29
30	V	12					35,380	35,380	30
31	V	14					91	91	31
32	V	17					180,354	180,354	32
33	V	19					28,198	28,198	33
34	V	20					3,907	3,907	34
35	V	21					89,362	89,362	35
36	V	22					257,236	257,236	36
37	V	23					539	539	37
38	V	24					2,327	2,327	38
39	Total			$			$ 1,822,301	$ * 1,822,301	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CENTER # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25		$	Resurrection Healthcare/Resurrection Medical Center		$ 403	$ 403	15
16	V	26					39,026	39,026	16
17	V	30					98,368	98,368	17
18	V	35					10,221	10,221	18
19	V	39					264,727	264,727	19
20	V	40					4,469	4,469	20
21	V	17	Intercompany Contracted Services	949,785				(949,785)	21
22	V	39	Intercompany Pharmacy Charges	68,080				(68,080)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,017,865			$ 417,214	$ * (600,651)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RESURRECTION NURSING & REHABIL # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Not Applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION Cl # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Resurrection HC/Medical Center
Street Address: 7435 W. Talcott
City / State / Zip Code: Chicago, IL 60631
Phone Number: (773) 774-8000
Fax Number: (773) 594-7488

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Shared Communication Cost	# non-patient telephones	433		$ 1,303,085	$	1	$ 3,009	1
2	19	Shared Data Processing Cost	data processing time	6,893		7,766,925		145	163,384	2
3	21	Shared Patient Accounting Cost	gross revenue dollars	487,045,490		3,755,377		18,640,804	143,730	3
4	1	Shared Purchasing Cost	total dollars purchased	36,874,976		1,441,794		4,690	183	4
5	2	Shared Purchasing Cost	total dollars purchased	36,874,976		1,441,794		1,229	48	5
6	3	Shared Purchasing Cost	total dollars purchased	36,874,976		1,441,794		163,232	6,382	6
7	4	Shared Purchasing Cost	total dollars purchased	36,874,976		1,441,794		70,299	2,749	7
8	5	Shared Purchasing Cost	total dollars purchased	36,874,976		1,441,794		770	30	8
9	6	Shared Purchasing Cost	total dollars purchased	36,874,976		1,441,794		132,797	5,192	9
10	10	Shared Purchasing Cost	total dollars purchased	36,874,976		1,441,794		135,918	5,314	10
11	11	Shared Purchasing Cost	total dollars purchased	36,874,976		1,441,794		4,578	179	11
12	19	Shared Purchasing Cost	total dollars purchased	36,874,976		1,441,794		4,925	193	12
13	20	Shared Purchasing Cost	total dollars purchased	36,874,976		1,441,794		3,521	138	13
14	21	Shared Purchasing Cost	total dollars purchased	36,874,976		1,441,794		56,726	2,218	14
15	24	Shared Purchasing Cost	total dollars purchased	36,874,976		1,441,794		4,920	192	15
16	25	Shared Purchasing Cost	total dollars purchased	36,874,976		1,441,794		2,412	94	16
17	35	Shared Purchasing Cost	total dollars purchased	36,874,976		1,441,794		61,979	2,423	17
18	39	Shared Purchasing Cost	total dollars purchased	36,874,976		1,441,794		203,869	7,971	18
19	1	Home Office Cost	accumulated cost						90,137	19
20	2	Home Office Cost	accumulated cost						91,399	20
21	3	Home Office Cost	accumulated cost						72,124	21
22	4	Home Office Cost	accumulated cost						36,211	22
23	5	Home Office Cost	accumulated cost						41,429	23
24	6	Home Office Cost	accumulated cost						42,533	24
25	TOTALS					$ 34,452,297	$		$ 717,262	25

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION Cl # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Resurrection HC/Medical Center
Street Address: 7435 W. Talcott
City / State / Zip Code: Chicago, IL 60631
Phone Number: (773) 774-8000
Fax Number: (773) 594-7488

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	9	Home Office Cost	accumulated cost			$	$		$ 2,929	1
2	10	Home Office Cost	accumulated cost						755,385	2
3	10a	Home Office Cost	accumulated cost						57,931	3
4	11	Home Office Cost	accumulated cost						21,930	4
5	12	Home Office Cost	accumulated cost						35,380	5
6	14	Home Office Cost	accumulated cost						91	6
7	17	Home Office Cost	accumulated cost						180,354	7
8	19	Home Office Cost	accumulated cost						28,198	8
9	20	Home Office Cost	accumulated cost						3,907	9
10	21	Home Office Cost	accumulated cost						89,362	10
11	22	Home Office Cost	accumulated cost						257,236	11
12	23	Home Office Cost	accumulated cost						539	12
13	24	Home Office Cost	accumulated cost						2,327	13
14	25	Home Office Cost	accumulated cost						403	14
15	26	Home Office Cost	accumulated cost						39,026	15
16	30	Home Office Cost	accumulated cost						98,368	16
17	35	Home Office Cost	accumulated cost						10,221	17
18	39	Home Office Cost	accumulated cost						264,727	18
19	40	Home Office Cost	accumulated cost						4,469	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,852,783	25

Facility Name & ID Number RESURRECTION NURSING & REHABILI # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Supplemental Schedule											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number RESURRECTION NURSING & REHABILITA # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CENTER # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	N/A	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	N/A	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	N/A	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998		11
1999		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CENTER # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 99,460 B. General Construction Type: Exterior BRICK & BLOCK Frame STEEL Number of Stories 3 PLUS GROUND

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY AND	126,500	1983	$ 580,293	1
2	PARKING AREA				2
3	TOTALS	126,500		$ 580,293	3

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CENTER # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	298			1976	$ 6,276,546	$ 209,278	30	$ 209,278	$	$ 3,557,520	4
5				1976	1,733,006	4,130	VARIOUS	4,130		1,718,590	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	VARIOUS			1981	3,549		VARIOUS			3,549	10
11	VARIOUS			1983	35,281		VARIOUS			35,281	11
12	VARIOUS			1985	3,892	195	VARIOUS	195		3,120	12
13	VARIOUS			1986	14,629	731	VARIOUS	731		10,965	13
14	VARIOUS			1987	41,215	2,061	VARIOUS	2,061		28,854	14
15	VARIOUS			1988	40,512	2,026	VARIOUS	2,026		26,338	15
16	VARIOUS			1989	190,627	9,531	VARIOUS	9,531		114,372	16
17	VARIOUS			1990	171,816	8,591	VARIOUS	8,591		94,501	17
18	VARIOUS			1991	60,020	3,001	VARIOUS	3,001		30,010	18
19	VARIOUS			1992	107,965	5,398	VARIOUS	5,398		48,582	19
20	VARIOUS			1993	105,120	5,256	VARIOUS	5,256		42,048	20
21	VARIOUS			1994	259,632	12,982	VARIOUS	12,982		90,874	21
22	VARIOUS			1995	630,342	31,517	VARIOUS	31,517		189,102	22
23	PARKING LOT EXPANSION			1996	13,265	1,658	8	1,658		7,462	23
24	RENOVATION OF REHAB UNIT			1996	3,250	191	17	191		860	24
25	WINDOW TREATMENTS			1996	3,500	350	10	350		1,575	25
26	RENOVATION OF EMPLOYEE DINING AREA			1996	1,277	256	5	256		1,152	26
27	NEW DOOR FOR FRONT LOBBY			1996	976	65	15	65		293	27
28	RENOVATION OF SHOWER ROOM			1996	8,148	543	15	543		2,444	28
29	RENOVATION OF DINING AREAS			1996	59,265	3,520	17	3,520		15,840	29
30											30
31	Page 12A				1,214,698	104,907		104,907		362,310	31
32	Page 12B				218,731	7,437		7,437		14,440	32
33	Page 12C				46,878	99,881		100,329	448	3,474	33
34	Page 12D										34
35											35
36	TOTAL (lines 4 thru 35)				$ 11,244,140	$ 513,505		$ 513,953	$ 448	$ 6,403,556	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CENTER # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	HOT WATER HEATER			1996	14,900	1,490	10	1,490		6,705	9
10	NEW DOOR, GROUND FLOOR			1996	754	50	15	50		175	10
11	PARKING LOT ADDITION			1997	108,669	7,304	15	7,304		25,564	11
12	LANDSCAPING			1997	36,111	3,611	10	3,611		12,639	12
13	ELEVATOR RENOVATIONS			1997	37,893	1,895	20	1,895		6,633	13
14	WIRING FOR COMPUTER APPLICATIONS			1997	12,881	654	20	654		2,289	14
15	OCCUPATIONAL THERAPY RENOVATIONS			1997	240,950	14,172	17	14,172		49,603	15
16	DINING ROOM RENOVATIONS			1997	95,391	5,748	17	5,748		20,118	16
17	ROOFTOP HVAC UNITES, INCLUDING INSTALL			1997	220,226	14,110	15	14,110		49,385	17
18	CARPETING			1997	62,031	12,406	5	12,406		43,421	18
19	HAND RAILS			1997	24,153	1,646	15	1,646		5,761	19
20	NEW FLOOR TILES, INCLUDING INSTALL			1997	103,959	10,396	10	10,396		36,387	20
21	NEW CEILING TILES, INCLUDING INSTALL			1997	43,340	4,334	10	4,334		15,169	21
22	DESIGNS, DRAW, ETC FOR VARIOUS PROJECTS			1997	51,893	5,189	10	5,189		18,162	22
23	PATCH PAINT, ETC.			1997	47,600	9,520	5	9,520		33,320	23
24	DRAPERIES			1997	27,180	5,436	5	5,436		19,026	24
25	REPLACE LIGHTING FIXTURES			1997	5,887	588	10	588		2,058	25
26	RESTORE LAUNDRY ROOM TRENCH			1997	8,559	570	15	570		1,425	26
27	FIRE DAMPERS, INCLUDING INSTALL			1998	3,520	234	15	234		585	27
28	DESIGN SERVICES, FOOD SERVICE REMODEL			1998	2,607	260	10	260		650	28
29	ENTRANCEWAY CARPETING			1998	1,295	260	5	260		650	29
30	FIRST FLOOR REMODELING			1998	6,732	674	10	674		1,685	30
31	NURSE CALLLIGHT SYSTEM			1998	37,299	2,486	15	2,486		6,215	31
32	WORK STATIONS - SPEECH THERAPY			1998	6,405	428	15	428		1,070	32
33	AIR TEST & BALANCE - HVAC SYSTEM			1998	6,200	620	10	620		1,550	33
34	BY-PASS VALVE FOR BOILER			1998	2,963	296	10	296		740	34
35	HEATING COILS FOR AIR HANDLER			1998	5,300	530	10	530		1,325	35
36	TOTAL (lines 4 thru 35)				$ 1,214,698	$ 104,907		$ 104,907	$	$ 362,310	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CENTER # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CODE ALERT SYSTEM WITH INSTALLATION			2000	8,682	434	10	434		434	9
10	ELECTRICAL WORK 7/99			1999	2,005	67	15	67		134	10
11	DINING ROOM SHADES 12/99			1999	1,600	54	15	54		108	11
12	JOINT COMPOUND 12/99			1999	3,657	122	15	122		244	12
13	PRIMER, TINT, PAINT 12/99			1999	351	12	15	12		24	13
14	WALLPAPER 12/99			1999	428	15	15	15		30	14
15	PATIENT PHONES 12/99			1999	744	25	15	25		50	15
16	MESSAGE WAITING LINE CARDS & TRUNK CARDS 12/99			1999	4,337	144	15	144		288	16
17	WIRING 12/99			1999	1,184	40	15	40		80	17
18	WALLPAPER 12/99			1999	398	13	15	13		26	18
19	FLOORING - 3RD FLOOR - B WING 12/99			1999	16,835	561	15	561		1,122	19
20	CUBICLE CURTAINS 12/99			1999	4,221	140	15	140		280	20
21	PLANNING & PERMIT DRAWINGS 12/99			1999	630	21	15	21		42	21
22	DESIGN ON INTERNET 12/99			1999	1,258	42	15	42		84	22
23	WALLPAPER 12/99			1999	4,393	146	15	146		292	23
24	WALLPAPER SUPPLIES 12/99			1999	85	3	15	3		6	24
25	FLOORING - TV ROOM 12/99			1999	1,795	60	15	60		120	25
26	ALTERATIONS - 2ND FLOOR 12/99			1999	48,302	1,610	15	1,610		3,220	26
27	DESIGN DISHWASHING AREA 12/99			1999	4,856	162	15	162		324	27
28	HAND SINKS, DISHTABLES, DISHMACHINES, HEATERS 12/99			1999	43,113	1,437	15	1,437		2,874	28
29	DTI/PRI COMMUNICATION PACKAGE 12/99			1999	1,391	46	15	46		92	29
30	FLOORING - 3RD FLOOR - A WING 12/99			1999	18,525	617	15	617		1,234	30
31	FLOORING - 3RD FLOOR - C WING 12/99			1999	18,525	617	15	617		1,234	31
32	REMOVAL OF FLOOR TILE 12/99			1999	2,833	95	15	95		190	32
33	DOOR OPERATING SYSTEM 12/99			1999	2,758	92	15	92		184	33
34	FLOORING - 3RD FLOOR - D WING 12/99			1999	18,525	618	15	618		1,236	34
35	LIGHT FIXTURES 12/99			1999	7,300	244	15	244		488	35
36	TOTAL (lines 4 thru 35)				$ 218,731	$ 7,437		$ 7,437	$	$ 14,440	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CENTER # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LIGHT FIXTURES 12/99			1999	1,804	60	15	60		120	9
10	FIRE DAMPERS 12/99			1999	7,040	234	15	234		468	10
11	REPAIR OF STEAM LEAK 12/99			1999	1,598	54	15	54		108	11
12	HAND SINKS, DISHTABLES, DISHMACHINES 12/99			1999	3,047	201	15	201		402	12
13	HOT WATER HEATER			2000	28,907	964	15	964		1,928	13
14	LANDSCAPING 7/99			1999	1,948		15	195	195	195	14
15	REPLACE RELIEF VALVE HOT WATER TANK 11/99			1999	2,534		15	253	253	253	15
16											16
17											17
18	Alloc from Resurrection Health Care/Resurrection Medical Center					98,368		98,368			18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 46,878	$ 99,881		$ 100,329	$ 448	$ 3,474	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CENTER # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RESURRECTION NURSING & REHABILITAT # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 2,083,149	$ 208,416	$ 208,416	$		$ 1,501,868	37
38	Current Year Purchases	37,928	3,793	3,793			3,793	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 2,121,077	$ 212,209	$ 212,209	$		$ 1,505,661	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	FACILITY	FORD TRUCK	1999	$ 26,878	$ 1,029	$ 1,029	$		$ 1,029	42
43		BUICK CENTURY	1997	18,343	4,586	4,586			16,051	43
44										44
45										45
46	TOTALS			$ 45,221	$ 5,615	$ 5,615	$		$ 17,080	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 13,990,731	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 731,329	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 731,777	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 448	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 7,926,297	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	CHAPEL - VARIOUS	$ 18,534	$ 927	$ 17,149	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 18,534	$ 927	$ 17,149	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

RESURRECTION NURSING & REHABILITATION CENTER **0044362**

RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE

06/30/00

LINE 28: PRIOR YEARS

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
	2,083,149	208,416	208,416		1,501,868
TOTALS	2,083,149	208,416	208,416		1,501,868

LINE 29: CURRENT YEAR

	37,928	3,793	3,793		3,793
TOTALS	37,928	3,793	3,793		3,793

LINE 30: FULLY DEPRECIATED

TOTALS					

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CEN # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		298		$			3
4	Additions							4
5								5
6								6
7	TOTAL		298		$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 76,083 Description: Attached
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$ 0	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CENTER # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-1,3	hrs	$ 88,447		$ 14,905	$		$ 103,352	1
2	Licensed Speech and Language Development Therapist	39-1,3	hrs	47,100		3,146			50,246	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	219,828					219,828	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-1,3	# of prescrpts	186,485		1,056	886,164		1,073,705	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					123,481	127,328		250,809	13
14	TOTAL			$ 541,860		$ 142,588	$ 1,013,492		$ 1,697,940	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	55,339
2	Complex Medical Equip	
3	Oxygen	28,350
4	Equipment Rental	43,639
5		
6		
7		
8		
9		
10		
		127,328

	Outside Therapies (Column 5 - Other)	Amount
1	Laboratory	120,201
2	Radiology	3,280
3		
4		
5		
6		
7		
8		
9		
10		
		123,481

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CEN # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 34,631,826	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,011,000)	120,874,907		3
4	Supply Inventory (priced at)	5,578,357		4
5	Short-Term Investments	231,868		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	8,511,061		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	11,768,503		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 181,596,522	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	920,009		12
13	Land	47,550,668		13
14	Buildings, at Historical Cost	497,800,543		14
15	Leasehold Improvements, at Historical Cos	61,789,338		15
16	Equipment, at Historical Cost	272,750,948		16
17	Accumulated Depreciation (book methods)	(434,202,430)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	512,019,335		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 958,628,411	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,140,224,933	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 48,761,050	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	67,309		29
30	Accrued Salaries Payable	33,373,276		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	22,657,491		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 104,859,126	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	460,243,668		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule	77,486,590		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 537,730,258	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 642,589,384	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 497,635,549	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,140,224,933	$	48

***(See instructions.)**

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION C]# 0044362 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 06/30/00

OTHER CURRENT ASSETS:	Amount	Amount	OTHER CURRENT LIABILITIES:	Amount	Amount
Other Receivables	11,643,710		Accrued Expenses		
Estimated Third Party Receivable	124,793		Accrued R. E. Tax - Non Care Property		
			Estimated Third Party Payable	22,657,491	
	11,768,503			22,657,491	
OTHER NON CURRENT ASSETS:			OTHER NON CURRENT LIABILITIES:		
Construction In Progress	7,231,009		Deferred Occupancy & Care Revenue	38,713,666	
Deferred Finance Charge	6,962,764		Estimated Liability Claims	35,587,338	
Assets whose use is limited	476,347,734		Other Assets	3,185,586	
Other Assets	21,477,828				
	512,019,335			77,486,590	

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CENTER # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 495,640,751	1
2	Restatements (describe):		2
3	**Schedule attached**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 495,640,751	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	12,885,988	7
8	Aquisitions of Pooled Companies	6,137,257	8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	3,622,999	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Net assets released from restrictions**	(568,710)	15
16	Other (describe) **Unrealized Gain/Loss Change**	(10,060,736)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 12,016,798	17
	B. Transfers (Itemize):		
18	**Transfer to Sisters of the Resurrection**	(10,022,000)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (10,022,000)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 497,635,549	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	RESURRECTION NURSING & REH/ #	0044362	Report Period Beginning:	07/01/99	Ending:	**06/30/00**

Balance per General Ledger		#########
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		#########
Equity(Deficit) from Page 17 Col 1		#########
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		#########

Facility Name & ID Number RESURRECTION NURSING & REHABILITATI # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,593,475	1
2	Discounts and Allowances for all Levels	(3,680,324)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,913,151	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,546,121	6
7	Oxygen	194,706	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,740,827	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	36,723	13
14	Non-Patient Meals	17,727	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,366,402	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	952,895	21
22	Laundry	27,598	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 2,401,345	23
	D. Non-Operating Revenue		
24	Contributions	199	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 199	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	3,264	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,264	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,058,786	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,394,405	31
32	Health Care	5,626,282	32
33	General Administration	3,560,212	33
	B. Capital Expense		
34	Ownership	697,327	34
	C. Ancillary Expense		
35	Special Cost Centers	1,726,739	35
36	Provider Participation Fee	163,602	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,168,567	40
41	**Income before Income Taxes (line 30 minus line 40)****	890,219	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 890,219	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number RESURRECTION NURSING & RE **# 0044362** **Report Period Beginning:** **07/01/99** **Ending:** **06/30/00**

SUPPLEMENTAL SCHEDULE OF REVENUES
06/30/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	2,795
2	Misc. Income	469
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
	TOTALS	3,264

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CEN # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,940	2,080	$ 60,815	$ 29.24	1
2	Assistant Director of Nursing	1,776	2,080	58,865	28.30	2
3	Registered Nurses	79,557	89,418	1,989,567	22.25	3
4	Licensed Practical Nurses	16,973	19,466	276,148	14.19	4
5	Nurse Aides & Orderlies	172,671	193,222	1,947,764	10.08	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	12,185	13,712	355,375	25.92	7
8	Rehab/Therapy Aides	25,400	28,356	373,130	13.16	8
9	Activity Director	1,864	2,080	42,309	20.34	9
10	Activity Assistants	10,412	11,338	99,008	8.73	10
11	Social Service Workers	10,876	12,821	227,990	17.78	11
12	Dietician	3,795	4,160	59,705	14.35	12
13	Food Service Supervisor	3,001	3,529	67,859	19.23	13
14	Head Cook	7,949	8,999	109,390	12.16	14
15	Cook Helpers/Assistants					15
16	Dishwashers	37,278	40,857	338,431	8.28	16
17	Maintenance Workers	7,440	8,539	134,413	15.74	17
18	Housekeepers	30,988	34,875	318,850	9.14	18
19	Laundry	17,892	19,108	153,097	8.01	19
20	Administrator	1,840	2,080	81,700	39.28	20
21	Assistant Administrator					21
22	Other Administrative	1,840	2,080	130,720	62.85	22
23	Office Manager					23
24	Clerical	25,350	26,712	309,076	11.57	24
25	Vocational Instruction					25
26	Academic Instruction	1,920	2,080	49,400	23.75	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,848	2,080	46453	22.33	31
32	Other Health Cs Pharmacy	9,774	10,177	186485	18.32	32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	484,569	539,849	$ 7,416,550 *	$ 13.74	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	CONTRACT	18,876	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	PER SERV	35	10-3	38
39	Pharmacist Consultant	285/fee	9,448	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	UTILIZATION REVIEW	CONTRACT	2,550	10-3	47
48	MED RECORDS TRANSCRIPTION	FLAT FEE	6,215	10-3	48
49	TOTAL (lines 35 - 48)		$ 37,124		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,397	$ 169,914	10-3	50
51	Licensed Practical Nurses	387	11,719	10-3	51
52	Nurse Aides	4,088	79,014	10-3	52
53	TOTAL (lines 50 - 52)	7,872	$ 260,647		53

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CENTER # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number RESURRECTION NURSING & REHABILITAT # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
NORMA WILSON	Administrator	0	$ 81,700
ART KOWNIGSBERGER	Senior Svcs VP	0	130,720
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 212,420

B. Administrative - Other

Description	Amount
	$
Management Fees - Resurrection Healthcare Corp.	949,785
TOTAL (agree to Schedule V, line 17, col. 3)	$ 949,785
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR & R	Accounting	$ 147
Superior Consultants	MIS	11,729
QS/ 1 DATA Systems	Software	4,925
Seyfarth, Shaw, Fairweather & Geraldson	Legal Fees	687
	Collection Agency	643
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 18,131

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,450
Unemployment Compensation Insurance	10,029
FICA Taxes	544,989
Employee Health Insurance	925,519
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Life Insurance	11,589
Adoption Program	905
Retirement Plan	35,736
Group Disability Insurance	35,025
Employee Assistance Program	6,758
Pre-Employment Medical Screening	15,376
See attached schedule	274,497
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,914,874

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues & Subscriptions	11,211
Licenses	247
Advertising & Promotion	13,580
Related Party Allocation	4,045
Less: Public Relations Expense	( )
Non-allowable advertising	(13,580)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,503

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	12,853
Related Party Allocation	2,519
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,372

**See instructions.

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CE # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number RESURRECTION NURSING & REHABILITATION CENTER # 0044362 Report Period Beginning: 07/01/99 Ending: 06/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LSN $1687**

(3) Did the nursing home make political contributions or payments to a politica action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,500** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **163,602**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **17,727**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **KPMG PEAT MARWICK** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **NOT AVAILABLE**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw